separately identified and accounted for as related to the self insurance plan. If not separately identified, investment income will be treated according to Section 1.270 and/or Section 3.526. Any proceeds from these policies will be offset against the claims paid during the cost reporting period of receipt.

For purposes of implementing this section and payment plan, the terms self-insurance and self-funded are synonymous. Self-insurance is a means where a provider, either directly or indirectly or through a separate entity, trust or fund, undertakes the ultimate risk by assuming the actual liability for insurance costs as defined in this section. The creation of a separate entity, trust or fund for insurance purposes does not eliminate the provider's ultimate insurance risk or liability. Payment of insurance premiums to an insurance company, in the business of offering insurance to the general public, where such premiums are the final liability of the provider regardless of the actual cost incurred by the insurance company does not constitute self-insurance.

1.249 Provider Assessments or Provider Specific Taxes

Reimbursable expenses under these Methods will not include any cost attributable to taxes or assessments on occupied beds imposed by this State solely with respect to nursing homes or ICF-MRs.

1.250 Costs from Related Parties and Related Organizations

1.251 Allowable Related Party Costs

A nursing home may incur expenses for services, facilities and supplies furnished by organizations related to the nursing home by common ownership or control. In lieu of such expenses incurred by the nursing home, allowable expenses for payment may include the expenses incurred by the related organization for the furnished items. Allowable expenses must not exceed the lesser of:

a. The expense incurred by the related organization for the services, facilities or supplies which the related party furnished to the nursing home, or

b. The price of comparable services, facilities or supplies that could be purchased elsewhere.

The purpose of this principle is to avoid the payment of a profit factor to the nursing home through the related organization, and also to avoid payment of artificially inflated expenses which may be generated from less than "arm's length" bargaining.

1.252 Definitions for Related Parties

A "related party" or "related organization" is an individual or organization related to a nursing home by either common ownership or control.

"Related to the nursing home" means that the nursing home, to a significant extent, is associated or affiliated with, or has control of, or is controlled by, the organization furnishing the services, facilities or supplies.

"Common ownership" exists when an individual or individuals possess significant ownership or equity in the nursing home and in the institution or organization serving the nursing home.

"Control" exists where an individual or an organization has the power, directly or indirectly, significantly to influence or direct the actions or policies of an organization or institution.

"Immediate family relationships" include husband/wife, natural parent, child, sibling, adoptive child and adoptive parent, step-parent, step-child, step-sibling, father-in-law, mother-in-law, brother-in-law, sister-in-law, son-in-law, daughter-in-law, grandparent and grandchild.

1.253 Determination of Relatedness

In determining whether a nursing home is related to a supplying organization, the tests of common ownership and control are to be applied separately. If the elements of common ownership or control are not present in both organizations, the organizations are deemed not to be related to each other. The existence of an immediate family relationship will create a rebuttable presumption of relatedness.

a. "Related by Common Ownership." A determination as to whether an individual(s) or organization possesses significant ownership or equity in the nursing home organization and the supplying organization, so as to consider the organizations related by common ownership, should be made on the basis of the facts and circumstances in each case. This principle applies whether the nursing home or the supplying organization is a sole proprietorship, partnership, corporation, trust or estate, or any other form of business organization, proprietary or nonprofit. In the case of a nonprofit organization, ownership or equity interest will be determined by reference to the interest in the assets of the organization (for example, a reversionary interest provided for in the articles of incorporation of a nonprofit corporation).

b. "Related by Control." The term "control" includes any kind of control which is exercisable, regardless of legal enforceability. It is the reality of the control which is decisive, not its form or mode of its exercise. The facts and circumstances in each case must

be examined to ascertain whether legal or effective control does exist. Since a determination reached in a specific case represents a conclusion based on the entire body of facts and circumstances involved, such determination should not be used as a precedent in other cases unless the facts and circumstances are substantially the same.

c. "Exception." An exception is provided to the general rule applicable to related organizations. The exception is intended to cover situations where large quantities of goods and services are furnished to the general public and only incidentally are furnished to a nursing home by a related organization. The exception applies if the provider demonstrates to the satisfaction of the Department that the following criteria are met:

1. The supplying organization is a bona fide separate organization.

2. A substantial part of the supplying organization's business activity as engaged with the nursing home is transacted with other organizations not related to the nursing home and the supplier by common ownership or control AND there is an open, competitive market for the type of services, supplies or facilities furnished by the organization.

3. The services, supplies or facilities are those which commonly are obtained by nursing homes from other organizations and are not a basic element of patient care ordinarily furnished directly to patients in nursing home operations.

4. The charge to the nursing home is in line with the charge for such services, supplies or facilities in the open, competitive market, and no more than the charge made by the organization, under comparable circumstances, to other customers for such services, supplies or facilities.

If all the above conditions are met, the charge by the related supplier to the nursing home for such services, supplies or facilities shall be an allowed expense for payment.

1.254 Documentation

The nursing home must make available to the Department adequate documentation to support the costs incurred by the related organization, including access to the related organization's books and records concerning supplies and services furnished to the nursing home. Such documentation must include an identification of the organization's total costs, and the basis of allocation of direct and indirect costs to the nursing home and to other entities served.

1.255 Medicare Influence

Generally, the Department will refer to the Medicare Program's guidelines and interpretations when examining payment issues arising out of costs to related organizations.

1.256 Related Party Compensation

Any form of compensation to owners or related parties which is included in the payment rate must be reasonable and necessary. "Reasonable" means that the compensation should not exceed what would be paid by other nursing homes or the home in question for similar services. "Necessary" means that the services are required and commonly performed in other nursing homes and that, if the services were not performed by the owner or related individual, another person would have to be employed or contracted to perform them. Workers, who are members of the religious order (or society) which owns the nursing home, are to be treated as related parties under this section.

1.260 Employee Compensation

Any form of compensation which is included in the payment rate must be reasonable and necessary. "Reasonable" means that the compensation should not exceed what would be paid by other nursing homes or the home in question for similar services. "Necessary" means that the services are required and commonly performed in other nursing homes.

1.265 Out-of-State Travel

Out-of-state travel and related travel expenses shall not be allowed, except for travel expenses to and from the nursing home's home office. This provision shall not apply to travel within 100 miles of the Wisconsin border or to home office personnel with one or more nursing homes located outside the State of Wisconsin. Travel expenses shall include but not be limited to meals, lodging, transportation, and all training, seminar and convention fees and expenses associated with the out-of-state trip.

1.266 Definition of Investment Income

Investment income consists of the aggregate net amount from dividends, interest, rental income, interest earned on temporary investment of withholding taxes, as well as all gains and losses. If the aggregate net amount realized is a loss, the loss is not allowable.

1.270 Interest Expense on Working Capital Debt

Working capital loans are debts entered into by a provider to finance current operations until current cash flow allows payment of the debt. Such debts may carryover from a recent fiscal year to the current fiscal year. Only interest expense on operating working capital loans which are related to patient care shall be allowed to be included in the calculation of the administration and general allowance. The Department shall determine allowable expense and shall include the following adjustments.

1. Revenues from any invested funds shall be offset against working capital interest expense; such revenues remaining after the offset may be offset under Department policy in determining the property allowance per Section 3.500.

   a. Investment income earned by any home office, other corporate entity or organization, foundation or related party that has a purpose of furthering the goals and objectives of the nursing home or its related organizations, shall be offset against the nursing home's allowable interest expense. Long term interest expense and working capital interest expense shall be offset by investment income from all sources (including home office, other corporate entities or organizations, foundations and related parties). Offsets from these entities shall be applied after offsets to interest expense at the home office, other corporate entities or organizations, foundations and related parties are made. Offsets to the nursing home shall be allocated based on the home office or foundation acceptable allocation basis. The investment income offset shall first be applied to working capital interest expense and then to long term interest expense.

   b. Investment income generated to meet specific financial reserve requirements of the Office of Commissioner of Insurance or other regulatory agencies will be exempt from the income offset requirement.

2. Interest expense on borrowed funds which are not used for operating the nursing home shall not be allowable.

3. An amount will be disallowed from working capital interest expense by applying an 8.3% per annum interest factor to the following amounts from the base cost reporting period. This standard disallowance shall only be applied to interest expense which exceeds $.10 per adjusted patient day (after applying 1 and 2 above).

   a. Disallowed compensation;

   b. Disallowed expenses;

   c. Stockholder dividends and owners equity distributions during the base cost reporting period;

4. This adjustment (4) will only be applied to any interest expense which exceeds $.20 per adjusted patient day after applying adjustment 3 above. An amount will be disallowed from interest expense by applying 8.3% to the following amounts from the cost reporting periods which were used in calculating the June 30th payment rate for the three years prior to the current payment rate year.

   a. Disallowed compensation;

   b. Disallowed expenses;

   c. Stockholder dividends and equity distributions during the cost reporting periods.

5. Interest on debts to acquire plant assets, which is not reimbursed under the property allowance in Section 3.500, shall not be allowed as interest in the administrative component.

1.281 Therapy and Beauty and Barber Shop Spaces

Support service, fuel and utility, property tax, and property expenses which are indirectly allocated to therapy services and beauty and barber services, on the basis of the building area which those services use, shall be generally allowed in the calculation of the payment rate. If gross therapy revenues (physical, occupational, and speech) are less than $100,000 for the applicable cost reporting period, then space allocations will not be made. If gross therapy revenues (physical therapy, occupational therapy, and speech therapy) generated in nursing home therapy space attributable to non-nursing home residents equal 2% or more of total gross therapy revenues and/or if the nursing facility (or a related party as defined in Section 1.252) bills Medicare Part B for therapy generated in the nursing facility therapy space and the Medicare Part B revenues equal 10% or more of the total therapy revenues, then space allocations shall be made on a square footage basis. If the nursing home is subject to an allocation under the Medicare Part B criterion, then the non-nursing home resident allocation will be made if there are any non-nursing home resident therapy revenues. These qualifying criteria are based on the facility's cost reporting period for the payment rates.

1.282 Transportation

Revenues from transportation services shall be offset against transportation or administrative cost center expenses. In lieu of a revenue offset, expenses appropriately allocated by the nursing home to the revenue-generating transportation services may be offset against the cost center expenses.

1.290 Institutions for Mental Disease and Mentally Ill Nursing Home Residents

Sections 1.291 through 1.294 describe limitations on payments to institutions for mental disease and nursing homes for the care of mentally ill residents, as required by 1987 Act 399.

1.291 Limitation on Payment
Operating, capital and ancillary costs attributable to the care of 21 through 64 year old residents of an institution for mental disease are not allowable costs, except that costs for 21 year old residents are allowable if the resident resided in the institution for mental disease immediately prior to turning 21.

1.292 Limitation on IMD Patient Days
This section applies to IMDs and facilities declared to be at risk of being IMDs which agree to receive a permanent limitation on payments, pursuant to s. 46.266(1)(am), Wis. Stats. For these facilities, costs attributable to Medicaid patient days in excess of the patient day cap are not allowable costs. The patient day cap is determined as follows:

Patient day cap = 365*[A + (B-C)], where

A = The number of Medicaid eligible residents of the facility on the date that it is declared an IMD or the date that it is declared at risk of being an IMD.

B = The total licensed beds in the facility on the date that the facility agrees to receive the permanent limitation on payments.

C = The total residents of the facility on the date that it is declared an IMD or the date that it is declared at risk of being an IMD.

The patient day cap may be increased by 365 patient days for each resident who was not eligible for Medicaid on the date the facility was declared an IMD or at risk of being an IMD, but who becomes eligible at a later date.

1.294 Cap on Mentally Ill Nursing Home Residents
Pursuant to s.49.45(6j), Wis. Stats., the number of mentally ill Medicaid recipients in a nursing home determined by the Department to be at risk of being an IMD may not exceed the average population of mentally ill Medicaid recipients age 21 through 64 (excluding persons under 22 who were receiving Medicaid services in the facility prior to July 1, 1988, and continuously thereafter) in the nursing home during the period from January 1, 1987, through June 30, 1988. Costs attributable to mentally ill residents of the facility in excess of the average population are not allowable costs.

1.296 Hospice
If an NF contracts with a hospice to provide care for a terminally ill resident, costs attributable to care for that resident are not allowable costs.

For cost allocation purposes, hospice patient days shall be treated as any Medicaid patient days for allocating all but direct care costs. To allocate direct care costs:

a. A residential level of care shall be assigned to hospice patient days for persons who are permanent residents of the facility; and

b. A medical level of care as appropriate shall be assigned to hospice patient days for persons admitted for temporary stays.

1.300 GENERAL DEFINITIONS

1.301 Active Treatment
Active treatment for developmentally disabled and mentally ill nursing home residents means an ongoing, organized effort to help each resident attain his or her developmental capacity through the resident's regular participation, in accordance with an individualized plan, in a program of activities designed to enable the resident to attain the optimal physical, intellectual, social and vocational levels of functioning of which he or she is capable.

1.302 Base Cost Reporting Period
Payment rates shall be based upon information from cost reports for the provider's fiscal year ending in the calendar year prior to effective date of the payment rates per Section 1.132, except that the property tax allowance shall be based on the cost reporting periods described under Section 3.400. Payment rates may be based on alternative cost reporting periods acceptable to the Department, whenever allowed under the provisions of Section 4.000 of this Methods.

Expenses included in a reporting period are to be on the accrual basis of accounting, except where otherwise noted. For reimbursement purposes, the accrued expense must be paid within 180 days following the end of the reporting period. An expense disallowed under this section in any cost report period may not be claimed on a subsequent cost report. Specific exceptions to the 180 day rule may be granted by the Department for documented contractual arrangements such as receivership, property tax installment payments, and pension contributions; or expenses relating to audit of another provider group if the audit settlement indicates acceptance of these costs in writing. Note Section 1.248 for pending claims for self-insurance costs.

For 2002-2003 rates, the facilities' 2001 cost reports will be used to calculate payment rates. Exceptions to this may be for facilities in a start-up or phase-down period per Sections 4.300, 4.400, 4.500 and 4.600 as mentioned in Section 1.302.

1.303 Common Period
The common period to which expenses will be inflated or deflated is the twelve-month period preceding the payment rate year described in Section 1.314. For 2002-2003 payment rates, the common period covers the twelve months of July 2001 through June 2002.

1.304 Definition of Significant Changes in Licensed Bed Capacity
Unless otherwise stated in this Methods, a significant increase or decrease in licensed bed capacity is defined as the lesser of: (1) a change that is greater than or equal to 25.0% of the previously unrestricted use licensed beds or (2) 50 beds.

1.305 New Facilities
A new facility is defined as a nursing home newly beginning operation and not previously licensed as a nursing home. A change in ownership does not constitute a new facility. An existing operation, which becomes certified for the Medicaid Program, shall not be considered a new facility.

1.306 Replacement Beds and Facilities
A replacement is defined as the licensure and certification by a Medicaid provider of beds to take the place of beds closed or de-licensed by the same or a related provider. Total replacement means all beds under a provider's certification were replaced. The resulting licensed bed capacity of the provider may be considered a significant increase or decrease in licensed beds if the criteria of Section 1.304 are met.

1.307 Adjusted Patient Days
The term "adjusted patient days" means patient days, including therapeutic and hospitalization bed hold days, as reduced to recognize the 15% discount on the payment rate for bed hold days and other adjustments determined by the Department. For example, 1000 patient days, including 100 bed hold days, would be reduced by 15 days (i.e. 15% x 100) to 985 adjusted patient days.

1.308 Fringe Benefits
The term "fringe benefits" refers to general fringe benefits for staff as defined in detail by the Department in the Medicaid nursing home cost report form. Significant, unique benefits, as defined in the cost report form, are to be included as a salary or wage expense under this Methods and not as a fringe benefit expense. For facilities with special salary and wage payments to employees, such as bonuses, the Department shall classify such payments as salaries instead of fringe benefits.

1.309 Average Licensed Beds
The term "average licensed beds" means the average of the number of licensed beds of the facility on the last day of each month of the period for which the average is being determined. An average for a one-month period shall be the average of the daily number of licensed beds.

1.310 Significant Licensed Bed Days
A significant number of licensed bed days is the lesser of 4500 licensed bed days or 25.0% of the annualized bed days of the provider.

1.311 Distinct Part ICF-MR
A distinct part ICF-MR is a specific segment of a licensed NF facility which has been certified by the Department as a distinct part intermediate care facility for the mentally retarded.

1.312 Institution for Mental Disease (IMD)
An institution for mental disease (IMD) is an institution that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases, including medical attention, nursing care and related services as determined by the Department or the federal Center for Medicare/Medicaid Services. An institution is an IMD if its overall character is that of a facility established and maintained primarily for the care and treatment of individuals with mental disease.

1.313 Restricted Use Beds
1. Restricted use beds are beds that exceed a nursing home's normal maximum bed capacity or are not in use due to remodeling. If a facility is remodeling a portion of the nursing home, and the beds will not be available until after the remodeling is complete, the beds are shown as restricted use beds. Beds may also be restricted use beds if they are transferred to a nursing home because of

one of the following three circumstances: 1) bankruptcy, 2) a physical plant with less than 50 beds that needs replacement, or 3) a physical plant with life safety code problems. This applies if space is currently not available for these beds.

1.314 Payment Rate Year
The payment rate year is the twelve month period from July 1, 2002 through June 30, 2003.

1.315 Patient Day
A patient day is one in which a patient, regardless of pay source, resides in a nursing facility for any part of a calendar day. This includes the day of admission but not the day of discharge. If the day of admission and discharge are the same it will be considered one patient day. Bed hold days reimbursed by the fiscal intermediary or patient are considered a patient day (Medicaid bed hold days must meet the billable criteria identified in Section 1.500.) A patient day can not be counted as both a patient day and a bed hold day.

1.316 Beds for Rate Setting
The beds for rate setting will be calculated as described in Section 3.040.

1.317 Medicaid Days
Only days of care for Medicaid residents that qualify for the nursing home fee-for-service benefit will be considered as Medicaid days for the Medicaid case mix indices (CMI) in section 3.122, the over-the- counter drug allowance in section 3.600 and for the special allowances for facilities operated by local units of government in section 3.775. The facilities' adjusted Medicaid days for the exceptional Medicare/Medicaid utilization incentive in section 3.651 shall include days of care for Family Care clients with a primary payor of Medicaid, Medicaid residents paid for by other states and residents funded by other Medicaid programs such as PACE, and Partnership in addition to days of care for fee-for-service residents.

1.400 NURSING HOME APPEALS BOARD

The Nursing Home Appeals Board is available for redress in the event a facility has extraordinary fiscal circumstances, as defined by statute. With the assistance of the Department, the Appeals Board shall develop written policies to ensure that the criteria required by statute are taken into account.

1.500 BED HOLD DAYS

Hospital bed hold days and therapeutic bed hold leave days will be paid at 85.0% of the full rate for qualifying facilities. A maximum of 15 consecutive days is payable for each hospitalization leave. In order to qualify to bill for bed hold, facilities must meet occupancy criteria below. (Reference: HFS 107.09(3)(j), Wis. Adm. Code).

1.510 Bed Hold Occupancy Requirements
Hospital and/or therapeutic bed hold leave can be billed to the Medicaid Program if the certified provider's occupancy level is an average of 8.0 or fewer vacant licensed beds, or a 95.0% or greater occupancy rate during the calendar month prior to the bed hold leave days. If either test is met, then the subsequent month's bed hold days may be billed. Minimum occupancy requirements for bed hold billing apply to new or expanded facilities. Homes in start-up must meet bed hold occupancy provisions.

Any facility pursuing a phase-down of resident population due to a licensed bed reduction or a phase-out may be exempted from the above occupancy requirements. The phase-down or phase-out and its expected time period must be approved in writing and in advance by the Department before such exemption shall be allowed.

1.520 Calculation of Occupancy for Bed Hold Billing
The occupancy in the month prior to the bed hold leave days shall be the basis for determining if the bed hold days in the subsequent month can be billed. Average vacant beds (for the "8.0 or fewer" test) shall be determined by subtracting the month's average midnight census days from the sum of the average licensed beds less any restricted use beds of each certified provider for the month. The occupancy rate (for the "95.0% or greater occupancy rate" test) shall be determined by dividing the total patient days by the number of licensed bed-days for the month. For this calculation only, licensed bed-days shall not include any restricted use beds. For the purposes of this calculation, bed hold days for any resident if charged at a level equal to or greater than 85% of the normal rate, shall be included as one full patient day.

1.521 Combined Occupancy Test for Multiple Providers
A provider, at its option, may combine the occupancy calculation under Section 1.520 for two or more separately certified facilities if the facilities are located on the same or contiguous property and are fully owned by the same corporation, governmental unit or group of individuals. The election to combine or separate facilities for the occupancy can differ from one month to the next month. Distinct part facilities may also utilize this occupancy test.

1.530 Excludable Licensed Beds

Licensed beds may be reduced for (a) isolation beds, (b) seclusion beds, (c) certain code violations, and (d) renovations in order to calculate the occupancy for bed hold billings. Excluded beds must meet one of the following criteria:

1. Isolation beds must be in rooms qualifying under HFS 132.84(12), Wis. Adm. Code, and used only for the temporary isolation of residents. Excluded licensed beds may not exceed one bed for every 100 beds or fraction thereof, unless more beds are specifically approved by the Department.
2. Seclusion beds (1) must be in a lockable room, the door to which required a licensure waiver, (2) must be used for seclusion only and always be available for seclusion, and (3) must be only used temporarily for calming disruptive residents. Only one licensed bed per seclusion room may be excluded.
3. For code violations, excluded beds must be out-of-use due to life safety code violations cited by the Department. The Department must be notified of such beds.
4. For renovation, licensed beds must be out-of-use due to renovation projects. The excluded beds and the expected time period of the exclusion must be prior approved by the Department.
5. Beds banked under Section 3.060.
6. Restricted Use Beds. Restricted use beds are defined in Section 1.313.

1.540 Documentation

Sufficient documentation by a certified provider assuring the Department that requirements permitting billing for bed hold days have been met must be provided upon request. If a certified provider does not supply sufficient documentation, payments for unsupported billings may be recouped by the Department.

1.550 No Charge to Resident and Third Party

NO RESIDENT OR THIRD PARTY MAY BE CHARGED FOR COVERED BUT UNREIMBURSED BED HOLD OR THERAPEUTIC BED HOLD LEAVE DAYS OR SERVICES OF A MEDICAID RECIPIENT. Beds held for the following leaves are deemed to be Medicaid-covered services, even when a certified provider does not meet the above occupancy requirements:

-- All hospital leaves of absence up through 15 days per hospitalization
-- All leaves for therapeutic visits
-- All leaves for therapeutic rehabilitative programs meeting the criteria under HFS 107.09(3)(j), Wis. Adm. Code.

1.600 RESOURCE ALLOCATION PROGRAM RATES AS A MAXIMUM

The per patient day property allowance stated in an application to the state's resource allocation program under Chapter 150, Wis. Stats., is the maximum allowable payment that may be granted by the Department for applications not involving the addition of beds for the first full year following completion of the project. In an application for approval of additional beds, the per patient day rate(s) stated in an application to the State's resource allocation program under Chapter 150, Wis. Stats., is the maximum allowable reimbursement that may be granted by the Department for the twelve months following licensure of the additional beds. If the Methods generates per patient day rates or per patient day property allowance that are less than those stated in the application, the Department shall use the lower rate(s) or allowance.

This section does not apply to ICF-MR facilities certified after June 30, 1988.

Resource Allocation Program maximums shall be applied for the first full year following completion of a project or the time period specified in the RAP approval.

1.700 CHAPTER 227 ADMINISTRATIVE HEARINGS

A facility may contest a final rate-setting action of the Department by writing to the Department of Administration's Division of Hearings and Appeals at P.O. Box 7875, Madison, WI 53707-7875. The rate approval letter issued to the facility by the Department is the formal written Notice of Action required by the state administrative code (Reference: HFS 106.12, Wis. Adm. Code). The request for hearing must be served within 15 days of receipt of a Notice of Action. It must contain a brief and plain statement identifying every matter or issue contested.

1.800 ADMINISTRATIVE REVIEWS

A facility may request an administrative review of the Department's cost finding decisions prior to the issuance of a rate approval letter. The request must be filed within 30 days of the facility's receipt of the notification of Medicaid nursing home rates and shall be subject to any other procedures or criteria developed by the Department. A facility's failure to file a timely request for an administrative review shall have no bearing on the facility's right to file a request for administrative hearing under Section 1.700 or an

appeal to the Nursing Home Appeals Board under Section 1.400 upon issuance of the rate approval letter. All administrative reviews should be sent to:

David Lund, Nursing Home Section Chief
Division of Health Care Financing
P.O. Box 309
1 West Wilson
Madison, WI 53701-0309

1.900 MEDICARE BILLING

Facilities must bill Medicare for covered services and supplies. Facilities that bill Medicare for applicable Part B services must be dually-certified facilities, and must bill Medicare for Medicare-covered services or supplies prior to billing Medicaid. Providers are expected to bill the Medicare Part B program for any services or supplies for residents covered by that program. Should a provider not exhaust Medicare Part B sources of revenue, then the Department may offset that amount or an estimate of that amount which could be billed to Medicare Part B. This policy applies to facilities which do not bill Medicare at all or do not exhaust Medicare to the extent available for applicable Medicare third-party liability.

SECTION 2.000 PAYMENT RATE ALLOWANCES DESCRIBED

This Methods provides for payments which are divided into seven major cost centers: Direct Care; Support Services; Administrative and General; Fuel and Utilities; Property Tax; Property and Over-the-Counter Drugs. Section 2.000 describes the types of services and costs generally covered by each cost center. The calculation of the payment allowances is described in Section 3.000.

2.100 DIRECT CARE ALLOWANCE

The direct care allowance shall reimburse for allowable facility expenses related to the provision of the following purchased and/or provided services and supplies, (which include, but are not limited to, staff wages, fringe benefits, and purchased services costs) up to maximums discussed in Section 3.100

2.110 Direct Care Direct Services

Direct Care Direct Services shall include all Registered Nurses, Nurse Practitioners, Licensed Practical Nurses, QMRP-Nursing, QMRP-Other, Nurse's Assistant, Resident Living Staff, Nurse Aide Training and Supplies, Ward Clerks, Non Billable – Physician, Active Treatment, Volunteer Coordinator, Social Service Personnel, Recreation Personnel, Religious Services and other special care.

2.120 Direct Care Supplies and Other Services

Direct Care Supplies and Other Services shall include Purchased Laundry-Diaper, Diapers & Underpads, Catheter & Irrigation Supplies, Other Medical Supplies, Non Billable – Lab, Non Billable -X-Ray, Non Billable – Pharmacy, Non Billable – PT, Non Billable – OT. Non Billable – Speech, Non Billable – Dental, Non Billable – Psychiatric Services, Non Billable – Respiratory Services, Non Billable – Physician Supplies, QMRP-Nursing Supplies, QMRP-Other Supplies, Active Treatment Supplies, Volunteer Coordinator Supplies, Social Service Supplies, Recreation Supplies, Religious Services Supplies and other special care supplies. Non-billable services generally include those types of services which are provided to the facility as a whole instead of to an individual resident and/or which are not billable separately to the Medicaid Program per HFS 107, Wis. Adm. Code.

2.130 Exclusions

The cost of non-covered services identified in HFS 107, Wis. Adm. Code or Department policies shall not be reimbursed.

Expenses for the time to perform overhead activities related to billable therapy evaluations, procedures and modalities are not to be included in the rate calculation and are not to be considered in the cost report category of "non-billable expenses." Activities such as end-of-the-day clean-up time, transportation time, consultation and required paper reports are considered to be overhead activities.

Any nursing personnel, quality assurance personnel and/or therapy consultants who do not provide direct, hands on patient care shall be considered administrative and general expenses. Personnel who provide inservice training are exempted from this provision: see Section 2.135.

2.135 Inservice Training

The expense of providing inservice training for any of the above personnel shall be included in the calculation of the direct care allowance. Expenses relating to nurse aide training and competency evaluation programs (NAT/CEP) mandated by OBRA shall not be included in the daily rate; separate reimbursement is provided for the direct expenses incurred by a nursing facility for NAT/CEP that is required before an aide can be entered on the Nurse Aide Registry.

Section 5.100 of this Methods contains further guidelines on, and a list of, supplies which are intended to be included under this provision.

2.200 SUPPORT SERVICES ALLOWANCES

The support services allowance recognizes the allowable expenses to provide dietary and environmental services up to amounts payable under Section 3.200. The expenses may include those salaries, employee fringe benefits, supplies, purchased services and other expenses which are directly related to providing the services.

2.210 Dietary Service Expenses

Dietary service expenses are those expenses directly related to the provision of meals to residents of the facility, including dietary supplements and dietician consultants.

2.220 Environmental Service Expenses

Environmental service expenses are generally those expenses related to the provision of maintenance, housekeeping, laundry and security services. Also included are expenses related to residents' personal laundry services, excluding personal dry cleaning services. Residents are NOT to be charged for the laundering of gowns.

2.250 Administrative and General Services Allowance

The administrative and general service allowance recognizes the allowable expenses for administrative, central office services and management services contract fees up to amounts payable under Section 3.250. The expenses may include those salaries, employee fringe benefits, supplies, purchased services and other expenses which are directly related to providing the services.

2.251 Administrative Service Expenses

Administrative service expenses include those expenses related to the operation's overall management and administration, and other allowable expenses which cannot be appropriately recognized/reimbursed in other payment allowances or service areas. Expenses for the provision of general administrative, clerical, financial, accounting, purchasing, data processing, medical records and similar services are usually considered administrative expenses. Also included are allowable expenses for non-medical transportation, telephone, office supplies, training fees, license fees, insurance (except property, mortgage and general employee benefit insurance), working capital interest expense, amortized financing acquisition costs and other similar expenses. A nursing home may also include the allowable ownership and/or rental expenses of telephone equipment, and computer and electronic data processing equipment. (Inservice training, see 2.135) (Legal expenses, see 1.245) (Interest expense, see 1.270)

2.252 Central Office Costs

Administrative expenses allocated to the nursing home from centralized administrative units of a nursing home chain organization, multi entity or governmental agencies shall be recognized among administrative service expenses, including the centralized unit's allocated overhead expenses such as maintenance, utilities and depreciation. Salaries and fringe benefits for any nursing personnel, quality assurance personnel, and therapy consultants who report to a centralized administrative unit, but do not provide direct hands-on patient care shall be included as central office costs. Expenses may be adjusted by the Department for unreasonable or unnecessary expenses or duplicative services.

A facility that claims both central office expense and in-house administrative and general expense will be subject to the following standards for reasonable and necessary salary and fringe benefit expense in this cost center:

If total in-house salary and fringe benefits plus management fees are greater than or equal $6.36 per patient day, no central service salary or fringe benefits is reimbursable.

If total in-house salary and fringe benefits plus management fees is less than $6.36 per patient day, then central service salary and fringe benefit expense is reimbursable up to a maximum of total in-house and central service salary and fringe benefits plus management fees of $6.36 per patient day.

2.253 Management Service Contract Fees

Management service contract fees shall be recognized among administrative service expenses, but may be adjusted by the Department for unreasonable or unnecessary levels of service, compensation, or duplicative services. Fees resulting from a percentage of cost or revenue arrangement will be disallowed by the Department, in whole or in part, according to the policy established by the Department. If actual management costs can be documented, those costs (subject to Medicaid allowability) may be substituted for the amount reported up to the amount actually paid.

2.254 Nursing Home Valuations

The cost of Department-required nursing home property valuations conducted by a Department-approved contractor shall be recognized among administrative service expenses.

2.300 FUEL AND OTHER UTILITY EXPENSE ALLOWANCE

The fuel and other utility expense allowance shall consist of allowable facility expenses related to the provision of electricity, water and sewer services, and heating fuel including fuel oil, natural gas, LP gas, coal and other heating fuels.

2.400 PROPERTY TAX ALLOWANCE

2.410 Tax-Paying Facilities